FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014076

Facility Name: Sunny Hill Skilled Rehab Ctr

Address: 421 Doris Avenue (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-8710 **Fax #** (815) 727-8637

IDPA ID Number: 366006672001

Date of Initial License for Current Owners: 1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/02 to 11/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	250	Intermediate (ICF)	250	91,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,753	1,251	7,217	11,221	8
9	SNF/PED					9
10	ICF	54,421	15,963	3,730	74,114	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,174	17,214	10,947	85,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.93%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 7,217

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: No tax year Fiscal Year: 11/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	661,065		16,069	677,134		677,134		677,134			1
2	Food Purchase		540,974		540,974		540,974	(2,059)	538,915			2
3	Housekeeping	758,589	98,361		856,950		856,950		856,950			3
4	Laundry	191,618		23,977	215,595		215,595		215,595			4
5	Heat and Other Utilities			245,960	245,960		245,960		245,960			5
6	Maintenance	221,502	66,248	190,791	478,541		478,541		478,541			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,832,774	705,583	476,797	3,015,154		3,015,154	(2,059)	3,013,095			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,762,596	442,346	889,520	7,094,462		7,094,462	(7,302)	7,087,160			10
10a	Therapy		12,432	500,858	513,290		513,290	(39,807)	473,483			10a
11	Activities	230,449			230,449		230,449		230,449			11
12	Social Services	217,580			217,580		217,580		217,580			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,210,625	454,778	1,390,378	8,055,781		8,055,781	(47,109)	8,008,672			16
	C. General Administration											
17	Administrative	73,454			73,454		73,454		73,454			17
18	Directors Fees											18
19	Professional Services			90,049	90,049		90,049	452,270	542,319			19
20	Dues, Fees, Subscriptions & Promotions			25,411	25,411		25,411	(195)	25,216			20
21	Clerical & General Office Expenses	354,371	9,041	34,011	397,423		397,423	21,995	419,418			21
22	Employee Benefits & Payroll Taxes			59,079	59,079		59,079	3,382,948	3,442,027			22
23	Inservice Training & Education			3,229	3,229		3,229		3,229			23
24	Travel and Seminar			106	106		106		106			24
25	Other Admin. Staff Transportation			1,934	1,934		1,934		1,934			25
26	Insurance-Prop.Liab.Malpractice							297,351	297,351			26
27	Other (specify):*											27
28	**TOTAL General Administration**	427,825	9,041	213,819	650,685		650,685	4,154,369	4,805,054			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,471,224	1,169,402	2,080,994	11,721,620		11,721,620	4,105,201	15,826,821			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr #0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			302,920	302,920		302,920		302,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198	198		198	(198)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			57,562	57,562		57,562		57,562			35
36	Other (specify):*											36
37	**TOTAL Ownership**			360,680	360,680		360,680	(198)	360,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,082	19,044	192,126		192,126		192,126			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,800	82,800		82,800	81,450	164,250			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		173,082	101,844	274,926		274,926	81,450	356,376			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,471,224	1,342,484	2,543,518	12,357,226		12,357,226	4,186,453	16,543,679			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,059)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(198)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5a attached	(49,996)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (52,253)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,238,706		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 4,238,706		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 4,186,453		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr

ID# 0014076

Report Period Beginning: 12/01/02

Ending: 11/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,059)	0	0	0	0	0	0	0	0	0	0	(2,059)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,059)	0	0	0	0	0	0	0	0	0	0	(2,059)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	454,962	0	0	0	0	0	0	0	0	0	454,962	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	21,995	0	0	0	0	0	0	0	0	0	21,995	21
22	Employee Benefits & Payroll Taxes	0	3,382,948	0	0	0	0	0	0	0	0	0	3,382,948	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	297,351	0	0	0	0	0	0	0	0	0	297,351	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	4,157,256	0	0	0	0	0	0	0	0	0	4,157,256	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,059)	4,157,256	0	0	0	0	0	0	0	0	0	4,155,197	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(198)	0	0	0	0	0	0	0	0	0	0	(198)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(198)	0	0	0	0	0	0	0	0	0	0	(198)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	81,450	0	0	0	0	0	0	0	0	0	81,450	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	81,450	0	0	0	0	0	0	0	0	0	81,450	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,257)	4,238,706	0	0	0	0	0	0	0	0	0	4,236,449	45

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Will County	100	N/A		Will County	Joliet	Government

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional services	$	Will County	100.00%	$ 454,962	$ 454,962	1
2	V	21	Film processing		Will County	100.00%	21,995	21,995	2
3	V	22	Employee benefits		Will County	100.00%	3,382,948	3,382,948	3
4	V	26	Insurance		Will County	100.00%	297,351	297,351	4
5	V	42	Provider tax		Will County	100.00%	81,450	81,450	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 4,238,706	$ * 4,238,706	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached list of	County board									2
3	board members	member	Administrative	0.00	None	< 1 hour	0.00	N/A	None	N/A	3
4	No services have been provided to the nursing home by board members.										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Will County
Street Address: 302 North Chicago
City / State / Zip Code: Joliet IL 60432
Phone Number: (815) 740-4607
Fax Number: (815) 740-4319

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional services	Number of warrants	N/A	1	$ 454,962	$	1	$ 454,962	1
2	21	Film processing	Estimated time	N/A	1	21,995		1	21,995	2
3	22	Employee benefits	Direct cost	N/A	1	3,382,948		1	3,382,948	3
4	26	Insurance	Direct cost	N/A	1	297,351		1	297,351	4
5	42	Provider tax	Direct cost	N/A	1	81,450		1	81,450	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,238,706	$		$ 4,238,706	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Various		x	Finance charges							198	8
9	TOTAL Facility Related						$	$			$ 198	9
	B. Non-Facility Related*											
10												10
11								Less: non-allowable finance charges			(198)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (198)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

Not applicable - county does not pay real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Hill Skilled Rehab Ctr COUNTY Will

FACILITY IDPH LICENSE NUMBER 0014076

CONTACT PERSON REGARDING THIS REPORT Karen Sobero, Administrator

TELEPHONE (815) 727-8710 FAX #: (815) 727-8637

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - county does not pay real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 128,067 B. General Construction Type: Exterior Brick Frame Steel, concrete block Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		1972	$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1972	1972	$ 1,375,843	$ 34,396	40	$ 34,396	$	$ 1,094,938	4
5	150		1976	1976	1,198,083	29,952	40	29,952		823,680	5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1970	727		20			727	9
10	Landscaping			1972	51,575		10-20			51,575	10
11	Patching and Paving/Air Conditioning/Entrance			1973	37,155		10-20			37,155	11
12	Door			1974	38,466		20			38,466	12
13	Asphalt Paving			1975	155,856		15			155,856	13
14	Landscaping			1976	57,254		10-15			57,254	14
15	Sewer and Water			1976	26,031	868	30	868		23,870	15
16	Plumbing			1972	183,817		25			183,817	16
17	Heating and Electrical			1972	522,443		20			522,443	17
18	Plumbing			1976	262,534		25			262,534	18
19	Heating and Electrical			1976	508,942		20			508,942	19
20	Sprinkler System and Paving			1975	83,460		25			83,460	20
21	Repairs / Roof			1981	107,858		15			107,858	21
22	Building Improvement			1987	819,813	32,792	25	32,792		541,070	22
23	Reroof A & B Rood			1985	85,920	4,296	20	4,296		79,476	23
24	Parking Lot Lights			1989	3,040		15			3,040	24
25	Reroof / Hot Water			1992	162,867	8,143	20	8,143		93,645	25
26	Waser Repair			1992	3,284		3			3,284	26
27	Site Improvements			1993	101,451	6,764	15	6,764		71,022	27
28	Laundry Renovatron			1994	108,852	7,256	15	7,256		68,932	28
29	Paving Parking Lot			1995	66,260	4,417	15	4,417		37,544	29
30	Laundry, Air Conditioner			1996	362,815	30,235	12	30,235		226,762	30
31	Elevator Repair			1997	4,990	499	10	499		3,244	31
32	Tile			1992	7,040		5			7,040	32
33	Elevator Repair			1996	2,212		3			2,212	33
34	Sheeting			1993	3,685		3			3,685	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Site improvement	1998	$ 2,936	$ 294	10	$ 294	$	$ 1,617	37
38	Electrical work	1998	2,085	209	10	209		1,149	38
39	Plumbing repair	1998	2,440	244	10	244		1,342	39
40	Boiler repair	1998	4,273	427	10	427		2,349	40
41	Fence	1999	1,000	100	10	100		450	41
42	Air Conditioning Repair	1999	6,284	628	10	628		2,826	42
43	Boiler repair	1999	4,965	497	10	497		2,236	43
44	Doors	1999	4,842	484	10	484		2,178	44
45	Carpeting	1999	1,649	165	10	165		742	45
46	Nurses Station	1999	53,554	5,355	10	5,355		22,759	46
47	Wallpaper	2000	840	84	10	84		294	47
48	Vinyl Board	2000	823	82	10	82		287	48
49	Office Compressor	2000	1,205	120	10	120		420	49
50	Fire System	2000	3,441	344	10	344		1,204	50
51	Fence	2000	936	94	10	94		329	51
52	Air Ducts	2000	3,090	309	10	309		1,082	52
53	Service Work	2000	1,573	157	10	157		550	53
54	Parking Lot	2000	4,860	486	10	486		1,701	54
55	Circular Pumps	2000	1,079	108	10	108		378	55
56	Boiler repair	2001	5,326	533	10	533		1,332	56
57									57
58	Plumbing	2002	11,756	1,176	10	1,176		1,764	58
59	Air Cleaner	2002	2,020	202	10	202		303	59
60	Boiler	2002	5,658	567	10	567		850	60
61	HVAC Control	2002	2,800	280	10	280		420	61
62	Fire and Smoke Dampers	2002	26,087	2,609	10	2,609		3,913	62
63	Doors	2002	4,155	416	10	416		624	63
64	Fireproof Framing	2002	2,730	273	10	273		410	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,504,680	$ 175,861		$ 175,861	$	$ 5,147,040	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,504,680	$ 175,861		$ 175,861	$	$ 5,147,040	1
2	HVAC	2003	11,370	569	10	569		569	2
3	Plumbing	2003	11,833	592	10	592		592	3
4	Oven repairs	2003	3,020	151	10	151		151	4
5	Dishwasher repairs	2003	1,419	71	10	71		71	5
6	Garbage disposal	2003	2,429	121	10	121		121	6
7	Freezer doors	2003	5,610	281	10	281		281	7
8	Boiler repairs	2003	21,892	1,095	10	1,095		1,095	8
9	Entrance door repairs	2003	13,240	662	10	662		662	9
10	Washing machine repair	2003	1,045	52	10	52		52	10
11	Site improvement	2003	8,252	413	10	413		413	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,584,790	$ 179,868		$ 179,868	$	$ 5,151,047	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,225,656	$ 122,566	$ 122,566	$	10	$ 1,039,735	71
72	Current Year Purchases	9,727	486	486	(0)	10	486	72
73	Fully Depreciated Assets	768,603					768,603	73
74								74
75	TOTALS	$ 2,003,986	$ 123,052	$ 123,052	$ (0)		$ 1,808,824	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,613,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 302,920	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 302,920	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,959,871	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 57,562 Description: See attached schedule 14a
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a C3	hrs	$	2,558	$ 153,484	$	2,558	$ 153,484	1
2	Licensed Speech and Language Development Therapist	L 10a, C3	hrs		11	644		11	644	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C3	hrs		3,510	210,600		3,510	210,600	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescrpts				173,082		173,082	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Sch 16a				2,615	97,508	12,432	2,615	109,940	13
14	TOTAL			$	8,694	$ 462,236	$ 185,514	8,694	$ 647,750	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/01/02 to 11/30/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies	Total
Respiratory Therapy	L10a, C3	2,615	78,464	12,432	90,896
Radiology Services	L39, C3		12,351		12,351
Laboratory	L39, C3		6,693		6,693
Total			97,508	12,432	109,940

See Accountants' Compilation Report

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,000	13
14	Buildings, at Historical Cost	6,444,148	6,444,148	14
15	Leasehold Improvements, at Historical Cost	140,642	140,642	15
16	Equipment, at Historical Cost	1,993,107	2,003,986	16
17	Accumulated Depreciation (book methods)	(6,961,548)	(6,959,871)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,641,349	$ 1,653,905	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,641,349	$ 1,653,905	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,523	$ 84,523	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	797,966	797,966	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 882,489	$ 882,489	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 882,489	$ 882,489	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 758,860	$ 771,416	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,641,349	$ 1,653,905	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 964,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 964,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,755,580)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,755,580)	17
	B. Transfers (Itemize):		
18	**Interfund transfers**	2,550,043	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,550,043	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 758,860	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,637,149	1
2	Discounts and Allowances for all Levels	(37,562)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,599,587	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,059	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,059	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,601,646	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,015,154	31
32	Health Care	8,055,781	32
33	General Administration	650,685	33
	B. Capital Expense		
34	Ownership	360,680	34
	C. Ancillary Expense		
35	Special Cost Centers	192,126	35
36	Provider Participation Fee	82,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,357,226	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,755,580)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,755,580)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**
This entity is tax exempt

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,924	2,080	$ 75,198	$ 36.15	1
2	Assistant Director of Nursing	2,000	2,080	58,418	28.09	2
3	Registered Nurses	26,743	29,283	803,207	27.43	3
4	Licensed Practical Nurses	61,987	67,429	1,447,850	21.47	4
5	Nurse Aides & Orderlies	222,454	241,497	3,141,590	13.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,119	14,565	236,333	16.23	8
9	Activity Director	2,080	2,080	30,596	14.71	9
10	Activity Assistants	15,223	16,478	199,853	12.13	10
11	Social Service Workers	9,050	9,697	217,580	22.44	11
12	Dietician					12
13	Food Service Supervisor	4,011	4,160	96,994	23.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	46,963	49,241	564,071	11.46	15
16	Dishwashers					16
17	Maintenance Workers	9,210	9,986	221,502	22.18	17
18	Housekeepers	60,318	65,457	758,589	11.59	18
19	Laundry	16,034	17,400	191,618	11.01	19
20	Administrator	2,064	2,080	73,454	35.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,301	20,543	354,371	17.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	510,481	554,056	$ 8,471,224 *	$ 15.29	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 16,069	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	109	5,347	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	156	8,125	L10a, C3	40
41	Occupational Therapy Consultant	110	5,694	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	81	4,040	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	885	$ 39,275		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,601	$ 218,855	L10, C3	50
51	Licensed Practical Nurses	7,566	273,820	L10, C3	51
52	Nurse Aides	19,533	391,498	L10, C3	52
53	TOTAL (lines 50 - 52)	31,700	$ 884,173		53

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Sorbero	Administrator	0	$ 73,454
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,454

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 37,199
UHC/Accumed Systems	Computer	2,960
Health Data Systems In	Computer	10,309
Altschuler Melvoin&Glasser, LLP	Accounting	9,500
American Express Tax & Bus Svce	Accounting	9,118
Medworks Hlth Services	Drug Screening	2,981
St Joseph's Hospital	Medical Billing	12,364
Ralph Zuppa	Piano Tuner	60
Joliet Fed. Of Musicians	Music	2,065
Mutual of Omaha	Medicare Billing	3,343
Integrity Environmental Svce	Environmental consulting	150
See attached Schedule 21a		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,049

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 251,295
Unemployment Compensation Insurance	8,943
FICA Taxes	648,049
Employee Health Insurance	1,900,312
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	574,349
Uniforms	56,283
Employee morale	2,796
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,442,027

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,145
Health Care Worker Background Check	1,478
(Indicate # of checks performed 123)	
County Nursing Home Assn dues	2,670
Illinois Health Care Assn	11,849
Dues and subscriptions	2,234
MW Automated Time System license	1,035
Less: Public Relations Expense	(195)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 106

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunny Hill Skilled Rehab Ctr
Provider #: 0014076
12/01/02 to 11/30/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	90,049
Allocated from Will County	454,962
Out of period legal fees	(2,692)
Total (agree to Schedule V, line 19, column 8)	542,319

See Accountants' Compilation Report

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunny Hill Skilled Rehab Ctr # 0014076 Report Period Beginning: 12/01/02 Ending: 11/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $ 11,849; County NH Assn - $ 2,670**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **183,456** Line **L10, C2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,059**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wermer, Rogers, Daran & Ryan** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit is currently in process.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Sunny Hill Skilled Rehab** **01:25 PM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	4,186,453	equal to	4,186,453	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	302,920	equal to	302,920	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	57,562	equal to	57,562	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	382,587	equal to	513,290	-130,703	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	185,514	equal to	185,514	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	3,015,154	equal to	3,015,154	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	8,055,781	equal to	8,055,781	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	650,685	equal to	650,685	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	360,680	equal to	360,680	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	192,126	equal to	192,126	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	82,800	equal to	82,800	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	5,526,263	equal to	5,762,596	-236,333	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	230,449	equal to	230,449	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	217,580	equal to	217,580	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	661,065	equal to	661,065	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	221,502	equal to	221,502	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	758,589	equal to	758,589	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	191,618	equal to	191,618	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	73,454	equal to	73,454	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	354,371	equal to	354,371	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	8,471,224	equal to	8,471,224	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	16,069	< or = to	16,069	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	889,520	< or = to	889,520	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	73,454	equal to	73,454	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	90,049	equal to	90,049	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	3,442,027	equal to	3,442,027	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	25,216	equal to	25,216	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	106	equal to	106	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	164,250	equal to	82,800	81,450	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	3,382,948	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,217	equal to	7,217	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	4,238,706	equal to	4,238,706	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	25,000	equal to	25,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,584,790	equal to	6,584,790	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,003,986	equal to	2,003,986	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,959,871	equal to	6,959,871	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	758,860	equal to	758,860	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-2,755,580	equal to	-2,755,580	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,641,349	equal to	1,641,349	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/4/2005		01:25:45 PM		
HSA Number	?	Name	**Sunny Hill Skilled Rehab Ctr**				
Cost report period	From:	12/01/02	To:	11/30/03	Base Number	335	
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	109,500	Occupancy:	85,335	Pct. of occupancy:		77.93%	
Illinois Public Aid Support Rate			$				
Genl Services Salary/Wage:	1,832,774	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	427,825	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	8,471,224	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	3,442,027	Col 8, Line 22 ---Audit Adj:					
Total General Services:	3,013,095	Col 8, Line 8 ---Audit Adj:					
Total General Admin	4,805,054	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amou by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$1,832,774
Divided by Total Wages (Column 1, Line 44	$8,471,224
General service wages as percent of total wages	21.6353%
Employee Benefits (Column 10, Line 22	$3,442,027
Allocation of Employee Benefits to General Services Costs	$744,693
Plus Total General Services (Column 10, Line 8	$3,013,095
New Total General Services Cost	$3,757,788

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$427,825
Divided by Total Wages (Column 1, Line 45	$8,471,224
General administration wages as a percent of total wages	5.0503%
Employee Benefits (Column 10, Line 22	$3,442,027
Allocation of Emplayee Benefits to General Admin. Cost	$173,833
Plus Total General Administration (Column 10, Line 2	$4,805,054
Minus Total Fringe (Column 10, Line 2:	$3,442,027
New Total General Administration Cos	$1,536,860

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	23	divided by 2 =	11.5
Beginning Day + Ending Day	31	divided by 60.8 =	0.509868421
Beginning Year + Ending Year =	205	multiplied by 6 =	1230
Sum of the three lines			1242.009868
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			335

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$3,757,788	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$3,757,788

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$1,536,860	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$1,536,860
3 Total Updated Support Costs (1 + 2		$5,294,648

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $58.29

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$5,294,648
Total Patient Days (Cost Report	85,335
Support Costs per Diem	$62.05

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	109,500
Multiplied by	0.93
	101,835
Minus total Patient Day	85,335
	16,500
One-third of difference	5,500
Plus Total Patient Day	85,335
Adjusted Occupancy	90,835
Total Support Costs (Step II, C, 3, above	$5,294,648
Divided by Adjusted Occupany	90835
Support Costs Per Dien	$58.29

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to c greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$58.29
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$58.29
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$58.29
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II anc	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$58.29
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 01:25:45 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Sunny Hill Skilled Rehab Ctr**
ID: **0014076**

HSA No.: ? Own or Rent? (O or R): ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	300	Total Patient Days	85,335
Begin	**12/01/02**	Licensed Bed Days:	109,500	% Occupied	77.93%
End	**11/30/03**			Capital Days	101,835

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1979
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	6584790
2. Total licensed beds from cost report Page 2, Line 7, column 3	300
3. Line 1 divided by Line 2	$21,949
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	101,835
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	85,335
2. Total Licensed Bed Days * .93	101835
3. Capital Days (higher of Line 1 or Line 2)	101,835
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	72	1375843	99060696	12
2	2	76	1198083	91054308	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	70	727	50890	12
7	7	72	51575	3713400	12
8	8	73	37155	2712315	12
9	9	74	38466	2846484	12
10	10	75	155856	11689200	12
11	11	76	57254	4351304	12
12	12	76	26031	1978356	12
13	13	72	183817	13234824	12
14	14	72	522443	37615896	12
15	15	76	262534	19952584	12
16	16	76	508942	38679592	12
17	17	75	83460	6259500	12
18	18	81	107858	8736498	12
19	19	87	819813	71323731	12
20	20	85	85920	7303200	12
21	21	89	3040	270560	12
22	22	92	162867	14983764	12
23	23	92	3284	302128	12
24	24	93	101451	9434943	12
25	25	94	108852	10232088	12
26	26	95	66260	6294700	12
27	27	96	362815	34830240	12
28	28	97	4990	484030	12
29	29	92	7040	647680	12
30	30	96	2212	212352	12
31	31	93	3685	342705	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	98	2936	287728	12A
35	35	98	2085	204330	12A
36	36	98	2440	239120	12A
37	37	98	4273	418754	12A
38	38	99	1000	99000	12A
39	39	99	6284	622116	12A
40	40	99	4965	491535	12A
41	41	99	4842	479358	12A
42	42	99	1649	163251	12A
43	43	99	53554	5301846	12A
44	44	100	840	84000	12A
45	45	100	823	82300	12A
46	46	100	1205	120500	12A
47	47	100	3441	344100	12A
48	48	100	936	93600	12A
49	49	100	3090	309000	12A
50	50	100	1573	157300	12A
51	51	100	4860	486000	12A
52	52	100	1079	107900	12A
53	53	101	5326	537926	12A
54	54	0	0	0	12A
55	55	102	11756	1199112	12A
56	56	102	2020	206040	12A
57	57	102	5658	577116	12A
58	58	102	2800	285600	12A
59	59	102	26087	2660874	12A
60	60	102	4155	423810	12A
61	61	102	2730	278460	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	103	11370	1171110	12B
68	68	103	11833	1218799	12B
69	69	103	3020	311060	12B
70	70	103	1419	146157	12B
71	71	103	2429	250187	12B
72	72	103	5610	577830	12B
73	73	103	21892	2254876	12B
74	74	103	13240	1363720	12B
75	75	103	1045	107635	12B
76	76	103	8252	849956	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

523109974 6584790 79.44216505

Base Year = 1979

TABLE 1 error

Table 1 Uniform building Value

	Uniform Building Value	
Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	661,065	0	16,069	677,134	0	677,134	0	677,134
2. Food Purchase	0	540,974	0	540,974	0	540,974	-2,059	538,915
3. Housekeeping	758,589	98,361	0	856,950	0	856,950	0	856,950
4. Laundry	191,618	0	23,977	215,595	0	215,595	0	215,595
5. Heat and Other Utilities	0	0	245,960	245,960	0	245,960	0	245,960
6. Maintenance	221,502	66,248	190,791	478,541	0	478,541	0	478,541
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,832,774	705,583	476,797	3,015,154	0	3,015,154	-2,059	3,013,095
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	5,762,596	442,346	889,520	7,094,462	0	7,094,462	-7,302	7,087,160
10a. Therapy	0	12,432	500,858	513,290	0	513,290	-39,807	473,483
11. Activities	230,449	0	0	230,449	0	230,449	0	230,449
12. Social Services	217,580	0	0	217,580	0	217,580	0	217,580
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	6,210,625	454,778	1,390,378	8,055,781	0	8,055,781	-47,109	8,008,672
17. Administrative	73,454	0	0	73,454	0	73,454	0	73,454
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	90,049	90,049	0	90,049	452,270	542,319
20. Fees, Subscriptions & Promotion	0	0	25,411	25,411	0	25,411	-195	25,216
21. Clerical & General Office	354,371	9,041	34,011	397,423	0	397,423	21,995	419,418
22. Employee Benefits & Payroll	0	0	59,079	59,079	0	59,079	3,382,948	3,442,027
23. Inservice Training & Education	0	0	3,229	3,229	0	3,229	0	3,229
24. Travel and Seminar	0	0	106	106	0	106	0	106
25. Other Admin. Staff Trans	0	0	1,934	1,934	0	1,934	0	1,934
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	297,351	297,351
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	427,825	9,041	213,819	650,685	0	650,685	4,154,369	4,805,054
29. Total General Administrative	8,471,224	1,169,402	2,080,994	11,721,620	0	11,721,620	4,105,201	15,826,821
30. Depreciation	0	0	302,920	302,920	0	302,920	0	302,920
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	198	198	0	198	-198	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	57,562	57,562	0	57,562	0	57,562
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	360,680	360,680	0	360,680	-198	360,482
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	173,082	19,044	192,126	0	192,126	0	192,126
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,800	82,800	0	82,800	81,450	164,250
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	173,082	101,844	274,926	0	274,926	81,450	356,376
45. Grand Total	8,471,224	1,342,484	2,543,518	12,357,226	0	12,357,226	4,186,453	16,543,679

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	0	0
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	0	0
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,000	25,000
14. Buildings, at Historical Cost	6,444,148	6,444,148
15. Leasehold Improvements, Historical Cost	140,642	140,642
16. Equipment, at Historical Cost	1,993,107	2,003,986
17. Accumulated Depreciation (book methods)	-6,961,548	-6,959,871
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,641,349	1,653,905
25. Total Assets	1,641,349	1,653,905
CURRENT LIABILITIES		
26. Accounts Payable	84,523	84,523
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	797,966	797,966
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	882,489	882,489
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	882,489	882,489
47.Total Equity	758,860	771,416
48.Total Liabilities and Equity	1,641,349	1,653,905

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	9,637,149
2. Discounts and Allowances for all Levels	-37,562
Subtotal - Inpatient Care	9,599,587
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,059
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	2,059
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	9,601,646
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	6,852,030
42. Income Taxes	0
43. Net Income or Loss for the Year	6,852,030

Page	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	Provider Participation fee is linked from page 4